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Case Report

Milligan Morgan Conventional Hemorrhoidectomy and Integrative Approach Through Ayurveda in the Management of Grade Four Multiple Hemorrhoids

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Abstract

Introduction: Hemorrhoids are common anorectal conditions, and in advanced cases often require surgical intervention. Hemorrhoidectomy, though effective, can lead to complications such as pain, bleeding and anal stricture. Integrating Ayurvedic modalities with modern management may help optimize the outcome. Case Presentation: A 55-year-old male presented with fourth-degree internal hemorrhoids, with associated pain and prolapse for 15 days, and a history of intermittent rectal bleeding for 10 years. Examination revealed prolapsed, inflamed interno-external hemorrhoids at 3, 7, and 11 o'clock positions. Preoperative management included Inj. Taximax 1.5g twice a day for 3 days and *Jalaukavacharana* (leech therapy) to reduce inflammation. Hemorrhoidal artery ligation (HAL) with mucopexy was initially performed but failed; subsequently, Milligan-Morgan hemorrhoidectomy was carried out. Postoperatively, mild anal stricture was observed as a complication of surgery which was managed with Ayurvedic interventions. Results: Gradual wound healing with satisfactory post-operative recovery was observed along with improvement in anal stenosis. At six-months follow-up, the patient had complete recovery without recurrence of hemorrhoids or any complications. Conclusion: An integrative approach combining modern surgical methods with Ayurvedic therapies contributed to improved post-operative recovery and wound healing in grade IV hemorrhoids patient.

Keywords: Anal stricture, Integrated Ayurveda, Hemorrhoidectomy, *Matra basti*

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Introduction

Hemorrhoids is one of the most common anorectal conditions observed globally, so that 20th November is celebrated as World Piles Day to generate awareness in common people. Hemorrhoids are found as the most common colonoscopy finding (n=32, 50%) followed by fissure-in- ano and isolated rectal ulcer (1). Patients of hemorrhoids are usually asymptomatic but common symptoms include anal bleeding, mucous discharge, swelling, discomfort, pruritus ani whereas, pain is usually associated with inflamed hemorrhoids. In some cases, painless bleeding may land up in severe anemia so it warrants early detection and treatment.

Hemorrhoids are present in anal canal like a cushion, with abnormal vascular dilatation (2). When the supporting tissues of anal cushions deteriorate, they slide down out of anus. Old age, straining for stool, strenuous activities and sitting for long time are considered as contributory factors. Internal hemorrhoids are painless; bleeding is the most common symptom reported and pain is experienced in case of prolapse and strangulation due to ischemia. Depending upon degree of prolapse, they are classified as: 1) 1st degree hemorrhoids- anal cushions that do not prolapse, 2) 2nd degree hemorrhoids- one that prolapse on straining and reduce spontaneously, 3) 3rd degree hemorrhoids- hemorrhoids that prolapse on straining and have to be replaced manually, 4) 4th degree hemorrhoids- hemorrhoid prolapses and irreducible (3).

Hemorrhoids are treated both conservatively and surgically. 1st and 2nd degree hemorrhoids are generally treated by conservative measures. Non-operative measures like sclerotherapy, cryotherapy, rubber band ligation, laser ablation, infrared coagulation are used in the treatment of hemorrhoids whereas surgical procedures include Hemorrhoidal artery ligation (HAL), Open /closed hemorrhoidectomy and stapled hemorrhoidectomy (4).

Common complications post hemorrhoidectomy procedure are pain, bleeding, infection, anal stricture and incontinence. Pain is managed by conservative measures. Early post-operative bleeding can usually be controlled by pressure packing, injection of epinephrine containing solution or suture placement. Anal stricture is observed in ~4% of patients which increases when radical hemorrhoidectomy is performed with 3-4 piles removed in single sitting (5). Anal stricture is treated depending upon the

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severity. Minor stricture can be treated with conservative measures like stool softener, anal dilatation, whereas severe stricture requires anoplasty with flap reconstruction (6).

Here, presenting a case report of fourth degree multiple internal hemorrhoids, treated surgically. Integrated modern and Ayurvedic treatment protocol was followed Pre and Post open hemorrhoidectomy and consequent complications were managed.

Patient information

Chief complaints

A 55 years old male patient, presented to outpatient department of ITRA hospital, Jamnagar with complaints of pain and protrusion of mass per Anum for 15 days on 8th February 2025. Patient complained of having difficulty in bowel evacuation and occasional bleeding per rectum for 10 years (on and off). Patient had no history of any major medical illness. Patient had habit of chewing Pan masala for 30 years. No any significant family history was identified.

Physical examination

Per rectal examination showed 4th degree (prolapsed & inflamed) interno-external hemorrhoids at 3,7 and 11 O'clock positions. Surgery was advised to manage the prolapse of hemorrhoids. Final diagnosis was made as prolapsed interno-external hemorrhoids.

Therapeutic intervention

Investigations

All routine investigations of patients were done, Hemoglobin was 12gm%, Neutrophils 72.6% and ESR 96 mm/Hr. Rest of the investigations were within normal limit (Table no.1). Routine chest radiogram and ultrasound - abdomen were also found normal. Treatment was decided as an integrated approach, by use of Ayurvedic treatment and modern medicine. Treatment was started after obtaining the patient's consent.

Table 1: Laboratory investigations

Test Name	Result	Test Name	Result
Haemoglobin	12gm%	Random Blood Sugar	106 mg/dL
Total RBC	3.70 mill/mm^3	**Lipid Profile**	
Total WBC	7380/mm^3	S. Cholesterol	192mg/dL
Platelet count	549000/mm^3	S. Triglyceride	117mg/dL
Differential count		S. HDL	39.5mg/dL
Neutrophils	72.6%	S. LDL	129.1mg/dL
Lymplocytes	16.3%	S.VLDL	23.4mg/dL
Eosinophils	3.0%	**Renal Profile**	
Monocytes	6.9%	Urea	19mg/dL
Basophils	1.2%	Uric acid	5.57mg/dL
ESR	96mm/Hr	Creatine	1.11mg/dL
Hepatic profile		**Serology**	
Total Bilirubin	0.35mg/dL	HIV	Negative
SGOT	7 U/L	HBsAg	Negative
SGPT	14U/L	HCV, VDRL	Negative

Table 2: Details of treatment mentioned in following table

Sr. No.	Date	Treatment given	Patient status
1	08/02/2025	Patient visited OPD and admitted to IPD	Severe pain, mass protrusion per-ano, swelling
2	09/02/2025-11/02/2025	*Jalaukavacharan* (Leech therapy) 2 sittings, 3 jalauka IV antibiotic (Inj. Taximax 1.5g BD for 3 days	Pain and swelling reduced
3	12/02/2025	FGHAL with Mucopexy done	-
4	13/02/2025	Failure of HAL	Prolapse of hemorrhoids
5	17/02/2025	Milligan Morgan Hemorrhoidectomy done	Post-op wound at anal region
6	18/02/2025-25/02/2025	Daily dressing along with manual anal dilatation	Wound healing in progress with painful defecation
7	27/02/2025-08/03/2025	*Matra basti* with *Jatyadi taila* and dilatation with anal dilator No.4 for 10 min. daily	Better wound healing with effective relief in painful defecation
8	15/03/2025	1 month follow-up	Wound healed completely.
9	17/05/2025	3 months follow-up	Mild pain during defecation.
10	25/08/2025	6 months telephonic follow up	No any complaints.

(FGHAL- Finger-guided Hemorrhoidal Artery Ligation)

Follow up & Outcomes

In the immediate post-operative period after Milligan Morgan Hemorrhoidectomy (for 8 days, till falling off of hemorrhoidal stump), treatment regimen included daily dressing with manual anal dilatation, sitz bath with *Panchavalkala kwath (*Polyherbal decoction of- *Ficus bengalensis Linn., Ficus racemosa Linn., Ficus religiosa Linn., Thespesia populenoides L., Ficus lacor Buch-Ham.)* twice a day, and *Eranda Bhrishta Haritaki 5g* at bedtime with warm water.

Mild anal stricture was diagnosed clinically with resting score 4 and squeezing score 2 at the end of 1st week (Table no.3). From 2nd week, to treat mild anal stricture, *Matra basti* with *Jatyadi taila* (10ml) and dilatation with plastic anal dilator no. 4 was given for 10 days. Patient was advised to continue self-dilatation with anal dilator for further 7 days. Patient was followed up for 6 months and he had no any further complaints and on per rectal examination resting score and squeezing score were normal.

Table 3: Post-Hemorrhoidectomy assessment

Day	DRESS Score	VAS score (0-10)
Day-1	RS5/SQ?	8
Day-7	RS4/SQ2	8
Day-14	RS4/SQ3	5
Day-21	RS4/SQ3	3
Day-30	RS3/SQ3	1
Day-60	RS3/SQ3	0

DRESS- Digital Rectal Examination Scoring System (7), VAS- Visual Analogue Scale (8)

RS-Resting score, SQ- Squeeze score

Figure 1: Before surgery (Post Leech therapy)

Figure 2: Post FGHAL

Figure 3: Pre-op to hemorrhoidectomy

Figure 4: Post hemorrhoidectomy

Figure 5: Post-op Day-4

Figure 6: Post-op- Day-15

Figure 7: Post-op Day-30

Discussion

In the present case, as the hemorrhoids were markedly painful and inflamed, pre-operative optimization was done with intravenous antibiotics and *Jalaukavacharnan (Leech therapy)*, aimed to reduce local inflammation, vascular congestion and intra-operative blood loss. *Jalaukavacharana* is an Ayurvedic treatment, in which medicinal leeches suck the impure or clotted blood from extra cellular compartment employed to reduce local congestion and inflammation by withdrawing the inflammatory mediators (9). After *Jalaukavacharan* considerable reduction in pain and swelling was observed.

As the hemorrhoids were large and matted, there was significant chance of post-operative stricture so non-excisional procedure was planned. The advantages of non-excision of hemorrhoid are absence of fecal incontinence, anal stenosis and pain. Hemorrhoidal Artery Ligation (HAL), restricts filling of hemorrhoidal mass and mucopexy prevents prolapse of the same. Early and sudden recurrence in immediate post-operative period or late and progressive recurrence in late follow up period can be observed with HAL (10). In 15% patients recurrence was noted by Brown, Steven R. et al following HAL and mucopexy (11). In this case, on the 1st post operative day, patient strained for stool resulting into prolapse of hemorrhoids following pain and some bleeding, which was managed conservatively. So that, open hemorrhoidectomy was planned.

Excisional open hemorrhoidectomy (Milligan- Morgan) is the most preferred treatment for grade 3 & 4 internal hemorrhoids. With extensive dissection and incision below dentate line makes it a painful procedure and anal stricture, incontinence, discharge per Anum are few other complications experienced for weeks after surgery (12). To prevent stricture, it is recommended to leave bridge of skin in between two hemorrhoidectomy wounds. In this case, even after leaving the bridge in between, anal stenosis was observed which is due to matted piles with involvement of circumferential mucosa of anal canal, post-inflammatory fibrosis and sphincter spasm in response to pain.

Anal stenosis of varying grade is usually observed as a complication of various anorectal surgeries. For mild anal stenosis, non-operative measures are useful such as stool softener and gradual anal dilatation etc. If conservative measures fail to relieve symptoms, partial lateral internal sphincterotomy (PLIS) can be useful. For severe cases of anal stenosis, along with PLIS, anoplasty is required (13). Anal dilatation with dilator in the post hemorrhoidectomy 3rd week, especially in patients with 2-3 hemorrhoids is found effective in management of pain and stenosis (4). Controlled dilatation manually or with dilator favors soft healing, reduces spasm and pain (14).

Matra Basti, a medicated enema which contains small quantity of fat (oil or ghee) is a main part of holistic *Ayurvedic* approach towards management of post-operative anorectal cases such as fissure in ano and hemorrhoids (15). Wound healing without excessive fibrosis or cicatrization is crucial for ensuring favourable post-operative recovery in anorectal surgeries. *Matra Basti* helps in healing of the post-operative wound. It provides lubrication to the anal canal, pacifies *Vata Dosha* and reduces hypertonicity of the sphincter (16). Therefore, its concomitant use with anal dilatation may aid in reducing sphincter spasm, minimizing fibrosis, and preventing cicatricial narrowing of the anal canal. *Jatyadi taila* was used for *Matra Basti* here, which has anti-microbial, anti-inflammatory and wound healing properties (17,18). Ingredients like *Tuthha* (CuSO4) in *Jatyadi taila* has *lekhana i.e. scraping* action, which might be effective in reducing the fibrosis.

Warm Sitz bath has positive impact on reducing the pressure and electromyographic activity of internal sphincter which helps in reduction of pain at anal region (19). *Panchavalkala kwatha* is commonly used for local treatments such as sitz bath in anorectal conditions for cleansing wounds due to its anti-inflammatory and anti-bacterial properties (20,21,22). It helps to prevent infection and maintain the perianal hygiene.

In anorectal post-operative management, smooth bowel movement is crucial to facilitate wound healing and avoid congestion. *Erand Bhrishta Haritaki (*Powder of *Terminalia chebula* roasted in castor oil*)*, a mild laxative (*Anulomaka),* was used to facilitate easy evacuation of feces. Bulk forming diet rich in vegetables, whole grains, adequate amount of water and non-sedentary lifestyle has its importance in natural bowel movement.

Interventions such as *Matra Basti* with *Jatyadi taila*, hot sitz bath, and measures promoting smooth bowel movement may support wound healing, reduce sphincter spasm, and improve patient comfort following procedures for hemorrhoids and fissure-in-ano. Collectively, these *Ayurvedic* measures were found effective in preventing additional surgery and morbidity following conventional measures such as sphincterotomy and isolated anal dilatation.

Conclusion

This case highlights the challenges associated with HAL and mucopexy in advanced grade IV multiple hemorrhoids and demonstrates the potential benefit of an integrative perioperative approach combining conventional surgical management with *Ayurvedic* interventions. Adjunctive *Ayurvedic* treatment protocol which included *Jalaukavacharana*, *Matra Basti* with *Jatyadi taila*, *Panchavalkala Kwatha* for sitz bath, *Eranda Bhrishta Haritaki* was found safe and supportive in peri-operative period. This case highlights the potential role of integrative management in reducing post-operative complications, better wound healing and enhancing recovery in complex hemorrhoidal disease. Further randomized controlled studies are required to evaluate the efficacy and reproducibility of this integrative Ayurvedic protocol in the management of complex grade III and IV hemorrhoids.

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